DEDUCTIONS EFFECTIVE JANUARY 1, 2021

PLAN/COVERAGE DESCRIPTION		TOTAL MONTHLY PREMIUM	COUNTY MONTHLY SUBSIDY	EMPLOYEE MONTHLY SHARE
DELTA DENTAL PREMIER PPO - $1,600 ANNUAL MAXIMUM-INCLUDES ORTHODONTIC BENEFIT*				
For CCHP Alternate A Plan	Employee	$46.36	$33.81	$12.55
	Employee + 1	$117.51	$76.48	$41.03
	Family + 2 or more	$117.51	$76.48	$41.03
For CalPERS Health Plans	Employee	$46.36	$33.81	$12.55
	Employee + 1	$117.51	$76.48	$41.03
	Family + 2 or more	$117.51	$76.48	$41.03
Without a Health Plan	Employee	$46.36	$43.56	$2.80
	Employee + 1	$117.51	$98.46	$19.05
	Family + 2 or more	$117.51	$98.46	$19.05
DELTA CARE (HMO)				
For CCHP Alternate A Plan	Employee	$25.35	$22.30	$3.05
	Employee + 1	$54.78	$48.19	$6.59
	Family + 2 or more	$54.78	$48.19	$6.59
For CalPERS Health Plans	Employee	$25.35	$22.30	$3.05
	Employee + 1	$54.78	$48.19	$6.59
	Family + 2 or more	$54.78	$48.19	$6.59
Without a Health Plan	Employee	$25.35	$25.35	$0.00
	Employee + 1	$54.78	$54.78	$0.00
	Family + 2 or more	$54.78	$54.78	$0.00

* EMPLOYEE MONTHLY SHARE INCLUDES COST OF ORTHODONTIC BENEFIT

VSP VOLUNTARY VISION PLAN

	Employee	$9.98	$0.00	$9.98
	Employee + 1	$19.94	$0.00	$19.94
	Employee + 2 or more	$32.12	$0.00	$32.12